Some Features of Psychiatric Practice in Postwar Medical Care Planning*

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RECORDED history reveals that in the wake of war, man's confidence in mankind's intent to cooperate—individually or internationally—invariably diminishes and the feeling of guilt and distrust between men mounts. The present postwar period already contains ample evidence that these days are not to bring an exception.

Fragmentary reports of the state of mind, both singly and in the congregate, of those in defeat appear to indicate several clear-cut characteristics which are at variance in degree only with characteristics to be observed in the state of mind of those round about us and in victory. Briefly, these characteristics are:

1. *Despair*—be it of food or shelter or economic security or political expression or domestic compatibility.
2. *"Shock"*—be it in relation to an episode or a benumbing drift, wherein the individual (or his group) is dazed or absorbed in a day to day existence and permits or expects others to assume responsibility for his survival and also to provide a directional force to his liabilities.
3. *Disillusionment*—in goals, in principles and in people.
4. *Hatred*—which may be so diffuse and unfocused that it is taken out on anybody or on everything.
5. *Shame (or Guilt)*—wherein assault and truculent attitudes compulsively serve as a disguise and everybody or anything becomes a potential target. (On the battlefield, and whether or not in association with guilt, this characteristic is capitalized upon in the strategy of "the best defense is to attack and then to attack again and again.")
6. *Fear*—that is cloaked in uncertainty, with its resultant—a truncated morale.

The reactions to these characteristics are well known to those of you in clinical practice. For orientation purposes only and without further comment they may be listed, too, as: (1) Callousness; (2) Deception; (3) Demoralization (planlessness); (4) Docility ("vacuity")—intellectual, moral, politic, etc.; (5) Self-pity.

Although we see these characteristics of the state of mind in our erstwhile enemies, in the reactions to those characteristics we now observe much of ourselves. This universality of the characteristics of mental life in the wake of war, in the enemy or the ally, and the limited but far-reaching reactions in people or in governments to those characteristics must be respected and sharply observed in whatever program the practice of psychiatry is to function. The implication is plain: a broad basic interpretation of psychiatric concepts (with supplemental coloration by neurology and psychoanalysis), unidentified with a clinic *per se* or diagnostic pathologic analogies, must be repeatedly offered to the *mass* population which is distraught not only by personal aberrations but also by economic insecurity, political intrigue and feelings of religious betrayal.

Psychiatry is being widely heralded through the periodicals, the press, the movies and the radio. On the whole, it may be contended safely that much that is presented is good rather than bad, and that the public's reaction to it is generally favorable. There is grave doubt, however, that other professions are as favorably disposed. And though it is evident that extensive interest in psychosomatic medicine, in geriatics, in anthropologic research and in socio-economic analyses may assist psychiatry to become free and untainted to men at large—there are such indications here and there—nevertheless, increased unchecked alcoholism, extensive sex irregularities, and grossly compromised family patterns may serve to fetter psychiatry with even greater stigma than it has formerly known.

Today in California a great impetus to professional standing and training has been given by the establishment of the Langley Porter Clinic in San Francisco and by the extensive practical revision of the program of the Department of Mental Hygiene. There are other signals too—though not many—that a few short progressive strides will be tried, albeit hampered by slender budgets. These hopeful signs are referred to in order that we may not be too discouraged that the mill still grinds exceedingly slow.

Psychiatric practice, if it be such, must broaden to be more widely available and accessible to vocational placement and family counseling. Four features of family life in America that have immeasurably altered the home and child rearing should be seriously studied and appraised by psychiatry for their emotional impact alone on personal adjustment. This should be done either in close cooperation with case work or nursing care or health insurance or court action. The four features are:

1. Increased mobility and unrest.
2. Reduction in number of offspring, giving par-

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ents more free time and therefore: (a) a feeling of duty to inform themselves as to child development and training, (b) an obligation to apply the information, and, hence (c) a greater sense of guilt if they should fail in that obligation.

3. Emancipation of womanhood, with its higher education status and its keener occupational rivalry not only with men but also with its own.

4. Impact and influence of fourteen and more millions of ex-service personnel conditioned to rank, prerogatives, authority, rumor, indulgences, "gripes," and congregate rivalries—all specific and to a high degree foreign to civilian life.

The impact of the ex-serviceman and its effect upon his kin are not restricted to the home; they extend also to industrial output and community planning. These men and women of the services speak out bluntly about psychiatry when counseled apart and away from signs of authority. The psychiatrists' rôle at selection and induction; what the chaplain has advised; what the field representative of American Red Cross or a USO volunteer has said; what the medical officer has inferred—all this has given a tint to psychiatry that is not bright. Disciplinary hearings and military police supervision and courts martial decisions far away from the simplest psychiatric tolerance are other factors operating detrimentally. Still others are the psychiatric interviews, however skillful or adroit or however leisurely conducted, that left the serviceman stuck with a coded diagnosis, or sent him out again into action, or rushed him back from the front to be discharged with a marked form to confirm to all that his signs of maladaptation were traceable to infancy or puberty or both. Moreover, if a veteran is left abandoned to a generalized policy of medical care in which every disability or symptom is evaluated alongside the possibility of claim for monetary compensation, or if standing in line-ups or in bureau waiting rooms with other veterans convinces him that his medical care is comparative and he must compete for it, or if even excellent treatment is permitted to lapse and delays occur which permit him to "shop about"—then he is likely to reach such an attitude as to make the application of psychiatric principles practically impossible and even to be looked upon as ridiculous.

Another barrier to the veteran's acceptance of the value of psychiatry is that in the armed services, shackled by countless administrative tasks or sitting in perfunctory review board hearings, psychiatrists grow weary and are not regarded at their optimal best.

Civilian attitude toward psychiatry will have much to do with its acceptance by the veteran. Few veterans will utilize psychiatric services constructively or with assurance unless these same services are observed to be widely applicable and extensively used by civilians. If a veteran does avail himself of treatment and the civilian population has a scoffing attitude toward psychiatry—especially psychoanalytic psychiatry—then he will feel that, even though benefited by the treatment, he is further stigmatized.

Several bills before Congress (if they are enacted), as well as the Dean's Committee plan of the Veterans Administration and other current proposals, may help to clarify within the next decade some of the drawbacks from an overall psychiatric point of view which are perpetuated at the colossal and pagan shrines to the Goddess of Insanity.

The solution to most conduct problems is not in the acquisition of an increased academic knowledge. Instead, if properly analyzed, it is found to rest in the adaptability that comes from close living with mature and reliable adults who have themselves lived widely, tolerantly and courageously, and who have compensated constructively for their many errors. Therefore, a comprehensive program of psychiatric concepts should be first introduced—in early life—through public health organizations and the more progressive channels of education and welfare.

Since children in America are becoming more freely expressive, since adults are becoming more sensitized to early signs of distress and since our detection devices for those in difficulty are being perfected, it can appear that our conduct problems are on the increase. There is so large a backlog of undetected problems that an initial upsurge of additional problems, rather than an abrupt diminution, should be anticipated from the first. In the public domain, this one feature of administrative planning —more revelation and less resolution of problems initially—perplexes the legislator and pleases the contrarily scheming politician more than any other single factor. But to temporize or to defer action in the face of need for action—though this might be politically strategic—is to expose a compromising weakness that even today's psychiatric techniques, advanced and promising though they may appear to be, cannot neutralize nor hope to excuse. For as the alleviation of malnutrition and the widespread control of disease and pestilence have become global, albeit self-protectively, and the application of known public health protective devices ever so alertly introduced into every cabin, so too must psychiatry envisage a broader rôle and become extremely sensitive to all human conduct, at home and internationally. To lessen infant mortality and to extend the life span for humans, all in one generation, and not be concerned over the more and greater hardships those humans will be called upon to endure, is the seduction of scientific principle of the worst order.

To be structurally sound, any community-wide planning for psychiatric interpretation and service should be founded upon a broad base. It cannot limit itself to the analysis and the solution of problems. Such planning should recognize and emphasize the revolutionary changes in American family life which are now taking place, and the obsolete American school patterns which are now latent, and the aspects of both which contradict rather than complement one another. Finally, the professions, too, must be brought to awareness of their own inherent conflicts and limitations which tend to obscure mutual respect and resources.

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